STATE OF NORTH CAROLINA
THE NORTH CAROLINA MEDICAL CARE COMMISSION
Division of Health Service Regulation
(HOSPITAL)
EQUIPMENT AND/OR REFINANCING PROJECT
APPLICATION FOR PROJECT FINANCING ASSISTANCE
UNDER AUTHORITY OF THE HEALTH CARE FACILITIES FINANCE ACT

Pursuant to Chapter 131A of the North Carolina General Statutes, the undersigned hereby makes application for financing assistance for the proposed project described below:

1. Legal Name of Applicant: _____

2. Address of Applicant: _____
(Street and Number) (Zip)

_____
(City) (State)
(County)

_____
(Mailing Address if Different From Above)

3. Chief Executive Officer: _____

Phone No.: _____ Fax No: _____

Email address: _____

4. Project Contact Person: _____

Phone No.: _____ Fax No: _____

Email address: _____

5. Organization:

a. Ownership _____

b. Tax Status _____

6. Describe briefly but completely the scope of the proposed project:

_____

_____

_____

_____

_____

7. **Financial Information Applicable to This Project:**

A. Sources:

1. Cash and negotiable securities from reserves $_____

2. Principal amount of bonds to be issued _____

3. Interest earned during acquisition period _____

4. Other:_____ _____

5. Other:_____ _____

6. Other:_____ _____

7. Other:_____ _____

TOTAL SOURCES OF FUNDS $_____

8. **Have you completed any construction, renovation or purchase and installation of equipment which would be subject to review for licensure but which has not been reviewed by the Division of Health Service Regulation? If the answer is yes, please attach an explanation.**

9. **Do you have any outstanding licensure, certification or regulatory issues which have not been resolved as of the date of this application? If the answer is yes please attach an explanation.**

10. **Do you have any life safety issues which should be addressed as a part of this bond issue? If the answer is yes please attach an explanation.**

11. **Community Benefits Reporting – the attached form related to Community Benefits should be completed as a part of this application.**

12. **Project Cost Estimates:**

A. Project Costs

(1) Total Moveable Equipment Budget (including installation) $_____

(2) Total Fixed Equipment Budget (include description of scope of work) _____
Attach list of any construction projects associated with equipment installation

(3) Consultant Fees (Related to Project - List)

a._____ _____

b._____ _____

c._____ _____

(4) Refinancing Costs if Applicable

a. Amount required to prepay loan _____

b. Escrow amount to refund bonds _____

c. Other refinancing items

(i)_____ _____

(ii)_____ _____

TOTAL PROJECT COSTS $_____

13. **Financing Costs:**

(1) Capitalized Interest $_____

(2) Debt Service Reserve Fund _____

(3) Bond Insurance/Letter of Credit _____

(4) Underwriters' Discount/Placement Fee _____

(5) Other Cost of Issuance

a. Feasibility Fees _____

b. Accountants Fees _____

c. Legal Fees for Corporation Counsel _____

d. Bond Counsel _____

e. Rating Agencies _____

f. Trustee Fees _____

g. Printing Costs _____

h. Division of Health Service Regulation Reimbursables _____

i. Local Government Commission Reimbursables _____

j. Other: (List)

1) _____ _____

2) _____ _____

3) _____ _____

4) _____ _____

Total Financing Costs $_____

TOTAL PROJECT COSTS $_____

14. **Timetable for Equipment Purchases:**

A. Target date for beginning purchases_____

B. Target date for completion of purchases_____

C. Equipment purchases by fiscal year 200__

fiscal year 200__

fiscal year 200__

15. Equal Employment Opportunity Certification

This facility is committed to equal employment opportunity for all applicants and employees. Accordingly, this facility neither practices nor condones any form of discriminatory behavior against applicants or employees on the basis of race, color, national origin, religion, sex, age or handicapping condition.

The undersigned hereby certifies that the attachments and foregoing statements are correct to the best of his knowledge and belief.

Date_____

Name of Responsible Officer:_____

Title:_____

Signature of Officer:_____

_____

The following documents are enclosed for your review:

___ Project Justification Including Alternative Financing Considered

___ Effect of any proposed refinancing on debt-service payments

___ Certificate of Need, if required

___ ***** Preliminary Equipment List - (Provide an itemized breakdown of equipment over $100,000)

___ Preliminary Feasibility Study or Internally Generated Projection for at least one year past the projected purchases - actual debt service coverage for last audited year plus three years projected debt service coverage

___ Audited Financial Statements (including management letters for last three years)

Community Benefits/Charity Care

Hospitals applying for financing through the North Carolina Medical Care Commission should submit an NCHA ANDI Form with the application, listed as Form #3 under Hospital Forms.

Distribution

Forward original with attachments and two signed copies **without** attachments of this form to Mr. Robert J. Fitzgerald, Secretary.

Street Address For Overnight Delivery:
N.C. Medical Care Commission
701 Barbour Drive
Raleigh, North Carolina 27603

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2701 Mail Service Center
Raleigh, North Carolina 27699-2701

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